MONTANA MEDICAID CLAIM JUMPER

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CLAIMS PROCESSING TIMELINES

This article is designed to answer some of the frequently asked questions about Consultec's claims processing timelines, for both paper and electronic submissions. Payment cycles are run every other Wednesday night. Concurrently with the payment cycle, four adjudication cycles are run every two weeks on Mondays and Wednesdays. Adjudication cycles cause claims to be put into a "pended," "to be paid," or "to be denied" status. Payment cycles will result in claims being put in a "Paid" or "Denied" status. Claims are not available to be viewed by our Provider Relations staff until they have gone through an adjudication cycle.

After a paper claim is received at Consultec, how long does it take for the claim to be paid or denied? Due to manual data entry of paper claims, it takes on average four to six weeks.

If you run payment cycles every other Wednesday night, why is it that my Remittance Advice and Warrant are both dated for the following Monday? After each payment cycle Consultec sends electronic data tapes to DPHHS, who then use that data to generate your warrants and Remittance Advices the following Monday.

I wait until the day of Consultec's payment cycle to transmit my claims electronically. Why is this not a good idea? This is not a good idea for several reasons. There may be problems with your transmission. Please allow enough time after your transmission to receive notification of transmission problems from our EDI Help Desk and re-transmit if necessary. Also, you have a better chance of receiving payment on your claims if you transmit in time for them to go through a regular adjudication cycle prior to the payment cycle. If your claims are pended for any reason, there will be more time to get them out of the "pended" status. We recommend transmitting before the Monday immediately prior to the Wednesday payment cycle.

PROVIDER SURVEY ENCLOSED

YOUR RESPONSIBILITIES AS A MONTANA MEDICAID PROVIDER

In general, providers shall be entitled to payment from Medicaid for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- The provider is an eligible, enrolled Montana Medicaid provider.
- The services are covered by Montana Medicaid and have not been designated "cosmetic" or "investigational."
- The services are medically necessary in relation to the diagnosis for which care or service is required and no other less costly alternative is available, and prior authorization requirements are met if required.
- The covered services are within the scope of the provider's profession.
- The recipient is an eligible, non-restricted Medicaid recipient.
- The services are made part of the medical record.

A PROVIDER IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT AND CONSULTEC IN WRITING, IMMEDIATELY CONCERNING A CHANGE OF ADDRESS, NAME OR OWNERSHIP OF THE PROVIDER'S BUSINESS OR FACILITY, OR ANY CIRCUMSTANCES RELATING TO HIS/HER LEGAL STATUS WHICH MIGHT AFFECT LICENSURE OR THE TERMS OF OR PARTIES TO THE PROVIDER AGREEMENT.

As a condition of participation in the Montana Medicaid Program, all providers of service shall abide by all applicable rules of the Department and by all applicable State and Federal laws and regulations, including but not limited to: the Administrative Rules of Montana (ARM); the Code of Federal Regulations (CFR); the United States Code governing the Medicaid Program; and all state laws and rules governing the licensure and certification, as well as with the standards and ethics of their business or profession.

Providers shall not discriminate in the provision of service to eligible Medicaid recipients on the grounds of race, creed, color, sex, national origin, or handicap.

WHAT ARE CREDIT BALANCES AND HOW CAN THEY BE RESOLVED?

When a provider is in a "Credit Balance," it means that adjustments have been done to claims that have reduced the original payments. This results in the provider owing money to the Montana Department of Public Health and Human Services (DPHHS).

Credit Balances are reported in a separate section of the Remittance Advice titled "Credit Balance Claims." Credit balances can be resolved in either of two ways. If you are in a Credit Balance and are still actively submitting claims, you can let the amount you owe be worked off future claims. This is the easiest and less time consuming way. Another option and one you must use if you will not be submitting more claims is to send a check for the amount owed payable to DPHHS. This check must be sent to Consultec to the attention of Provider Relations Field Representative, P.O. Box 4936, Helena, MT 59604-4936. Please attach a note with your provider number on it that the check is for payment of your Credit Balance. Upon receipt of the check, Consultec will adjust our records to remove you from the "Credit Balance" status. Your check will be forwarded to DPHHS.

Recently Released Montana Medicaid Publications

The following is a list of publications released within the last quarter. If you would like extra copies of these publications, please contact Provider Relations.

Date	Sent to	Topic
1/28/2000	Physicians, Mid-Level Practitioners, Public Health Clinics	Immunization Administration and Vaccines for Children Program
February 2000	QMB Chiropractors and EPSDT Providers	Chiropractic Services Manual
2/22/2000	Pharmacy Providers	Increasing Drug Expenditures and Formulary Update
2/18/2000	Mental Health Centers	Reimbursement Available to MHC Psychiatrists and Physicians for E & M Services
3/1/2000	Mental Health Providers	Use of Modifier for Assessment of Psychiatric Crises and Initial Intakes
3/20/2000	Physicians, Mid-Level Practitioners, EPSDT Providers, Podiatrists, Dentists, Optometrists, Audiologists, Public Health Clinics, Psychiatrists	Global Surgery Periods

RECIPIENT COPAYMENT

Providers may choose to collect recipient copayment at the time of service or bill the recipient later. It is not required that you collect copayment. According to federal regulation, a provider cannot deny services to a Medicaid recipient due to the recipient=s inability to pay the copayment at the time services are rendered. However, the recipient=s inability to pay the copayment at the time services are rendered does not lessen the recipient=s obligation to pay the copayment.

As providers, you must treat the Medicaid patient and the private pay patient equally. If you refer the private pay patient to a collection agency for failure to pay for services rendered, you may also refer the Medicaid patient to a collection agency for failure to pay copayment charges. If it is your office policy to request the private pay patient to seek another health care provider at the time you refer to a collection agency, then you may also request the Medicaid patient to seek another health care provider at the time you refer to a collection agency.

It is suggested a notice be posted in the waiting room explaining to all patients the office=s policy regarding the patient=s responsibility for payment, including the cost-sharing obligation (copayment).

CONSULTEC FIELD REPRESENTATIVE AVAILABLE FOR ON-SITE VISITS

Consultec has a Provider Relations Field Representative who is available for visits to your offices and facilities. Her name is Robin Lyda and she can assist with Medicaid training of established and new billing staff, as well as ACE$ training and installation. If you would like to schedule a visit with our Field Representative, please call Provider Relations.

INFORMATION TELEPHONE NUMBERS

Provider Relations	1-800-624-3958 (Montana Providers) 1-406-442-1837 (Helena and Out-of-State Providers) 1-406-442-4402 (FAX)		
FAXBACK	1-800-714-0075	AUTOMATED VOICE RESPONSE	1-800-714-0060
Point-of-Sale Help Desk	1-800-365-4944	PASSPORT	1-800-480-6823
Direct Deposit	1-406-444-5283	HMO – BC/BS HMO – YCHP	1-800-447-8747 1-800-721-3057

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MONTANA MEDICAID

CONSULTEC

P.O. BOX 8000
HELENA, MT 59604

ACE$ ACCELERATED CLAIMS ENTRY SOFTWARE

EMC Becoming EDI

Consultec's EMC Help Desk will be changing its name to the EDI Help Desk. EDI stands for Electronic Data Interchange, versus EMC which stood for Electronic Media Claims. This name change is for several reasons. First, EDI is more of an industry standard term for electronic transmissions of data. Second, Consultec accepts more than just claims by electronic means. For example, we receive recipient eligibility data and prior authorization information electronically.

ACE$ HELPFUL HINTS

In each issue of the "Claim Jumper" we will include some helpful hints on ACE$, Consultec's new electronic claims submission software. ACE$ Maintenance Tables are a real time saver for you. You can build maintenance tables on your provider numbers, recipients, and procedure codes (procedure code maintenance available on HCFA-1500 only). Use of these maintenance tables will save you time and effort in reducing your keystrokes during entry of your claims information.

Occasionally during transmission of your claims, you may receive the following message, "Unexpected response from host." This message indicates a busy signal. Please try transmitting again in a few minutes.